MICHIGAN DEPARTMENT OF COMMUNITY HEALTH
Bureau of Health Systems
Division of Licensing & Certification
Substance Abuse Licensing Section
P. O. Box 30664
Lansing, Michigan 48909

DIRECTIONS FOR COMPLETING THE APPLICATION FOR LICENSURE AS A SUBSTANCE ABUSE PROGRAM

ALL APPLICANTS

Complete the white license application **UNLESS** application or renewal is only for prevention services. Prevention-only applicants are to complete the pink application.

WAIVER REQUESTS

Applicants who want to request a waiver of any licensing rule for the first time must complete the green Appendix A form. If you presently have a waiver and wish to renew the request, complete the "Waiver Renewal Only" portion on the bottom of page 4 of the application.

APPROVED SERVICE PROGRAM/RESIDENTIAL SUB-ACUTE DETOXIFICATION

Applicants providing residential substance abuse services who wish to be designated as an “Approved Service Provider” or licensed to provide "Residential Sub-Acute Detoxification" are to complete the yellow Appendix B form and submit it with the white application.

P.A. 309 SCREENING AND ASSESSMENT PROVIDER

To be designated as a screening and assessment provider under P.A. 309, you must be licensed for Casefinding-Screening, Assessment, Referral, and Follow-Up (SARF) and complete the blue Appendix C form and submit it with the white application.

Questions pertaining to the submission of any of the above-mentioned forms can be answered by contacting the Substance Abuse Licensing Section (SALS) at (517) 241-1970.

DEFINITIONS OF TERMS IN THE LICENSE APPLICATION*

LICENSED SERVICE CATEGORIES

Prevention - Services that reduce the risk that an individual will develop problems which might require that he or she enter the substance abuse treatment system.

Prevention-CAIT - A prevention service that provides at least one of the following services:

> Prevention-Community Change - Planned efforts which are designed to change specific conditions so as to reduce the probability that substance use problems will occur among residents of the community.
>
> Prevention- Alternatives - Providing planned non-treatment personal growth activities which we designed to help a participant meet his or *her* own Personal needs *and* to reduce him or her risk of developing problems which might require that he or she enter the substance abuse treatment system.
>
> Prevention-Information - Providing information to the public which is designed to reduce the risk that an individual will develop problems which might require that he or she enter the substance abuse treatment center.
>
> Prevention-Training - Providing activities which we designed to improve the personal and social skills of a person who wishes to avoid substance use problems or who is in a position to help others avoid problems with substance use.

Prevention-Problem Assistance - Helping a person with an acute personal problem involving or related to substance abuse to reduce the risk that the person might be required to enter the substance abuse treatment system.

Casefinding - The process of systematically interacting with the community for the purposes of identifying persons in need of services, alerting persons and their families to the availability of services, locating needed services, and enabling persons to enter the service delivery system.

> Casefinding-Organizational Development - Planned efforts designed to change specific community or organizational conditions so that the probability increases that persons with substance use problems will obtain appropriate treatment. The targets of organizational development activity are those various institutions and groups existing in each community which are not currently integrated into the substance abuse service delivery network.
>
> Casefinding-Screening, Assessment, Referral, and Follow-Up (SARF) - Means the performance of a range of activities necessary to make preliminary assessments of problems. The object of these activities, which may include interviews, psychological tests, and other diagnostic or assessment tools, is to effect referrals to appropriate treatment or assistance resources if indicated.

Treatment - An emergency, outpatient, intermediate, or inpatient service and care, and may include diagnostic evaluation, medical, psychiatric, psychological, social service care, and referral services which may be extended to an individual who is or appears to be incapacitated.

Outpatient Care - Scheduled, periodic care, including diagnosis and therapy, in a non-residential setting. Correctional institutions are considered non-residential settings.

Methadone Treatment - Chemotherapy using the drugs methadone or LAAM (levo-alpha- acetylmethadol) as rehabilitation tools in conjunction with other treatment and rehabilitation care.

Inpatient Care -Substance abuse treatment services that are provided to a person within a hospital setting under medical supervision. Inpatient care may include both emergency services and non-emergency services. Inpatient care is provided in hospitals operated by the Department of Mental Health or in beds licensed by the Michigan Department of Community Health.

Residential Care - Substance abuse services that are provided in a full or partial residential setting. Such services may be supplemented with diagnostic services, counseling, vocational rehabilitation, work therapy, or other services which are judged to be valuable to clients in a therapeutic setting. Residential care is not provided in beds also licensed by the Michigan Department of Community Health.

TYPE OF CARE NEEDED BY CLIENT

Acute Care - Acute substance abuse treatment is for conditions that are life-threatening due to intoxication with alcohol or other drugs or chemicals. Acute care is physician directed/supervised medical care in an inpatient setting.

Sub-acute Care - Sub-acute substance abuse treatment is for conditions that are not life-threatening but require a coordinated treatment program which may include detoxification, individual and group counseling, chemotherapy, medical care or other appropriate services deemed necessary by the professional supervised treatment staff.

TYPE OF CARE PROVIDED BY PROGRAM

Detoxification - Detoxification treatment means a medically acute or sub-acute systematic reduction of the amount of a drug in the body, or the elimination of a drug from the body concomitant with supportive treatment services. Detoxification typically lasts 3-5 days. Inpatient programs provide acute detoxification services typically lasting 3-5 days in hospital beds licensed by the Michigan Department of Community Health. Residential-Approved Service programs and others provide sub-acute detoxification services typically lasting 3-5 days.

Rehabilitation - The act of restoring an individual to a state of mental and physical health or useful activity through vocational or educational training, therapy, and counseling.

Intermediate Care/Rehabilitation - Programs which typically do not exceed 45 days in duration. Such residential/inpatient programs have an organized treatment staff supervised by a master's degree (or equivalent) professional responsible for overall quality of clinical care. Planned individual or group treatment services typically do not exceed 30-45 days duration. Intermediate care may be delivered in delicensed or off-line inpatient beds.

Long-Term Therapeutic Community - A long-term residential program that is structured as a drug-free living situation in which the primary therapeutic tool is the supportive or confrontive peer interaction of the residents. Individual and group counseling are built into structured daily routines. Treatment typically exceeds 60 days.

Long-Term Halfway House - An establishment with administrative supervision that provides -- through permanent facilities and guidance personnel -- resident beds, structured or supervised peer group living, and limited health-related services emphasizing social rehabilitation with support and guidance toward the goals of independent living for its residents, who have problems related to substance abuse. Halfway house care typically lasts six months or more.

*See Public Act 368 of 1978, as amended, Article 6 and Rules for full set of definitions.

Michigan Department of Community Health Substance Abuse Licensing Section **APPLICATION FOR A SUBSTANCE ABUSE LICENSE**	Check all ☐ MASTER SITE that apply: ☐ SATELLITE LOCATION ☐ INITIAL ☐ RENEWAL LICENSE NUMBER: _____ CA NUMBER: _____ CONSULTANT: _____ DATE DUE: _____
RETURN THIS **ORIGINAL** APPLICATION TO: Michigan Department of Community Health Bureau of Health Systems Division of Licensing & Certification Substance Abuse Licensing Section P. O. Box 30664 Lansing, Michigan 48909	***Mail copy of Application to the Regional Coordinating Agency listed on page 12 which corresponds with the "CA Number" listed above.***

In accordance with the provisions of Act 368 of the Public Acts of 1978, as amended, and the Administrative Rules (R 325.14101-R 325.14928) of the Michigan Department of Community Health, Substance Abuse Licensing Section, the undersigned hereby applies for a license to operate a substance abuse treatment, rehabilitation and/or prevention program.

DATE SUBMITTED _____

PROGRAM LEGAL NAME _____

STREET ADDRESS _____

P.O. BOX (If applicable) _____ COUNTY _____

CITY _____ MI, Zip _____ PHONE _____/_____
Area Code

E-MAIL _____ FAX# _____

INDICATE THE TYPE OF ORGANIZATION THAT IS LEGALLY RESPONSIBLE FOR OPERATION OF THE PROGRAM. PLEASE COMPLETE BOTH PARTS A AND B.

A. ☐ For Profit
☐ Non-Profit

B. ☐ Sole Ownership
☐ Corporation
☐ Partnership
☐ City Government
☐ County Government
☐ State Government
☐ Hospital Authority
☐ Other-Specify _____

DAYS/HOURS OF OPERATION: _____

PROGRAM DIRECTOR'S NAME: _____

LICENSED SERVICES AND CAPACITY

For this program, indicate the service (s) for which licensure or special designation is requested. The terms used are defined in the Administrative Rules (R 325.14101 to R 325.14103) and on page two.

☐ **PREVENTION**

☐ Community Change, Alternatives, Information, Training
Check if classes are offered: (1)* ☐ Highway Safety Education ☐ Other Classes

☐ Problem Assistance

☐ **CASEFINDING**

☐ Organizational Development

☐ Screening, Assessment, Referral & Follow-Up

☐ **OUTPATIENT**

☐ Alcohol and Drug Free (Non-Day Care)

☐ Methadone (2)* Must request Methadone Application

☐ Day Care

☐ **RESIDENTIAL**

☐ Sub-Acute Detoxification
Must submit Appendix B (attached)

☐ Intermediate Care

☐ Long-Term Therapeutic Care

☐ Long-Term Halfway

Number of Beds (3)*_____

☐ **INPATIENT**

Number of Beds (3)* _____
MDCH Licensed Beds (4)* _____
License # _____

☐ **SPECIAL DESIGNATION**

☐ Screening and Assessment Agent (Drunk-driving court referrals) (5)*
Must submit Appendix C (attached)

☐ **REQUEST FOR WAIVER OF RULE**

☐ New Requests for Waiver of a Licensing Rule
A separate waiver request form must be completed. Must submit Appendix A (attached).

☐ Waiver Renewal Only
Cite rule number for which waiver request has been granted by the Substance Abuse Licensing Section and for which a renewal is being requested. Rule # _____ Rule: _____

*See Explanatory Footnotes on page 5

EXPLANATORY FOOTNOTES - FOR PAGE FOUR (4) OF APPLICATION

(1) Check if substance abuse/alcohol highway safety education or other classes are offered by the program on a routine basis.

(2) Programs that utilize controlled substances, including methadone, must complete a separate State Methadone Approval Application (BHS/L&C-103).

(3) If substance abuse beds are part of a unit which also provides beds for non-substance abuse clients, estimate the number of substance abuse beds, using the maximum beds which substance abusers would fill at any point in time.

(4) Required if substance abuse beds are licensed by the Department of Community Health typically as medical/surgical beds or as psychiatric beds. Indicate license number.

(5) An application for designation must be filed - complete Appendix C. A license for Screening, Assessment, Referral and Follow-Up (SARF) is required. Criteria additional to licensing standards must also be met by applicant.

SATELLITE LOCATIONS

A program that operates in more than one location (site) must list the names and addresses of all sites operating under the same governing authority in the space provided below as well as the service categories at each site. The **Master Site** is the location which provides direct substance abuse services and where all administrative functions are located. This site is determined by the program, not Michigan Department of Community Health. If the administrative office does not provide services, this location should be indicated below.

MASTER SITE: LICENSE #_______________ Telephone #_________________________

Name of Program ____

Program Director ____

LICENSE #__________
Service Category
1)________________
2)________________
3)________________
4)________________

Name of Program ____
Address ________________________________ City _______________
Zip _________ County _____________ Telephone# ( )_______________
Site Director ____________________________ Number of therapists:________
Average Client Population: ________ Avg. Monthly Client Population:__________

LICENSE #__________
Service Category
1)________________
2)________________
3)________________
4)________________

Name of Program ____
Address ________________________________ City _______________
Zip _________ County _____________ Telephone# ( )_______________
Site Director ____________________________ Number of therapists:________
Average Client Population: ________ Avg. Monthly Client Population:__________

LICENSE #__________
Service Category
1)________________
2)________________
3)________________
4)________________

Name of Program ____
Address ________________________________ City _______________
Zip _________ County _____________ Telephone# ( )_______________
Site Director ____________________________ Number of therapists:________
Average Client Population: ________ Avg. Monthly Client Population:__________

LICENSE #__________
Service Category
1)________________
2)________________
3)________________
4)________________

Name of Program ____
Address ________________________________ City _______________
Zip _________ County _____________ Telephone# ( )_______________
Site Director ____________________________ Number of therapists:________
Average Client Population: ________ Avg. Monthly Client Population:__________

LICENSE #__________
Service Category
1)________________
2)________________
3)________________
4)________________

Name of Program ____
Address ________________________________ City _______________
Zip _________ County _____________ Telephone# ( )_______________
Site Director ____________________________ Number of therapists:________
Average Client Population: ________ Avg. Monthly Client Population:__________

GOVERNING AUTHORITY

List all the members of the governing authority, i.e., owner, stockholders, shareholders, board of trustees, board of directors, who have legal and ethical responsibility for the program. Provide all requested information. If the governing authority is delegated, as by a city council or county board of commissioners, attach evidence of delegation. **NOTE:** If a member of the governing authority provides services, a waiver of Rule 109(1) must be requested. Also indicate if a member receives pay for services provided to the program.

Name and Board Position	Address

1) Please indicate if a board member is a paid member for services provided to this program.
2) Please indicate if board member is related to a staff member of program.
3) If the current governing authority is listed in another recent program license application, reference the program name and license number where this information may be found. Program Name: _____ License# _____

ACCREDITATIONS, LICENSES AND/OR APPROVALS

Please indicate below all accreditation, licenses, and/or approvals that have been obtained or are being sought for the program. If the approval, license, or accreditation is under a name different from that listed for the substance abuse license, please give the name under which the other license is issued. **PLEASE SUBMIT <u>DOCUMENTATION OF CURRENT ACCREDITATION.</u>**

Program Name _____

LICENSE	APPLIED	APPROVED	EXPIRATION DATE	PROVIDER NUMBER
American Osteopathic Association (AOA)	( )	( )	_____	_____
Blue Cross/Blue Shield, Approved Substance Abuse	( )	( )	_____	_____
Blue Cross/Blue Shield. Outpatient Psychiatric Clinic (OPC)	( )	( )	_____	_____
Commission on Accreditation of Rehabilitation Facilities (CARF)	( )	( )	_____	_____
Council on Accreditation of Services for Families and Children (COA)	( )	( )	_____	_____
Department of Social Services, Child Care Institution	( )	( )	_____	_____
Joint Commission on Accreditation of Healthcare Organizations (JCAHO)	( )	( )	_____	_____
Medicaid Approved	( )	( )	_____	_____
Medicare Approved	( )	( )	_____	_____
Other- Specify _____	( )	( )	_____	_____

APPLICATION ATTACHMENTS

PROGRAM DESCRIPTION

Items A – L as identified below. The attachments must be clearly labeled with the program's 1) name; 2) license number as shown on the front of the application; and 3) date submitted. DO NOT submit copies of your operating procedure manual. We desire a description of the specific policies and procedures called for below. Actual formats used need not be submitted; they will be reviewed at the preliminary licensing inspection. All new applicants MUST SUBMIT ITEMS A - I AND ITEM L. Item L requires that you submit a copy of your notice of intent. This can be a copy of a legal ad from your local newspaper indicating that your program is applying for a substance abuse license OR a copy of a notice which you sent to local churches, schools and incorporated non-profit civic organizations with the names and addresses to whom the notice was sent. Please see sample notice on page twelve (10).

RENEWAL APPLICANTS: If the attachments for Items A - I have not changed since your previous submission, check the box that says, "See Prior Application". If an item has changed since your previous application, attach it and mark the box titled "Attached." If your program has a number of sites which are licensed (listed on page 6 of this application), your attachments for the master site MUST describe the services provided at all of your locations, i.e., your admission procedures should describe policies for outpatient, residential, etc.

A. **PROGRAM PHILOSOPHY. GOALS & OBJECTIVES.**
☐ Attached ☐ See Prior Application ☐ New Satellite Ref. Lic. #_____

B. **TARGET POPULATIONS.** Specify geographic service delivery area and groups toward which services will be directed.
☐ Attached ☐ See Prior Application ☐ New Satellite Ref. Lic. #_____

C. **METHODOLOGY.** Describe the methods, procedures and activities used to reach program goals and objectives. Describe individual or group counseling, family therapy, outreach efforts, etc. Prevention programs should indicate the specific activities provided. Describe classes offered (size, content, duration).
☐ Attached ☐ See Prior Application ☐ New Satellite Ref. Lic. #_____

D. **ORGANIZATIONAL STRUCTURE.** Provide an organizational chart of your program. If part of a larger organization, show relationship.
☐ Attached ☐ See Prior Application ☐ New Satellite Ref. Lic. #_____

E. **ADMISSION CRITERIA & INTAKE PROCEDURES.** Describe your program's admission/eligibility criteria and intake process and policies. DO NOT submit forms which you use to carry out these processes.
☐ Attached ☐ See Prior Application ☐ New Satellite Ref. Lic. #_____

F. **DISCHARGE POLICIES & PROCEDURES.** Describe your program's discharge criteria, policies and procedures.
☐ Attached ☐ See Prior Application ☐ New Satellite Ref. Lic #_____
☐ N/A

G. **AFTERCARE & FOLLOW UP POLICIES & PROCEDURES.** Describe your program's aftercare services and client follow-up evaluation policies and procedures. If not applicable, please so indicate.
☐ Attached ☐ See Prior Application ☐ New Satellite Ref. Lic. #_____
☐ N/A

H. **RECIPIENT RIGHTS POLICY & PROCEDURES.** Using the "Model Recipient Rights Policy and Procedures" document, develop and submit your program's recipient rights policies and procedures.

☐ Attached ☐ See Prior Application ☐ New Satellite Ref. Lic. #_____

I. **CONFIDENTIALITY OF CLIENT DATA.** Describe the procedures your program utilizes to assure that all client records are kept confidential. Emphasis should be placed on where client records are stored and measure taken to assure that all records are secure and not available to persons other than staff. DO NOT submit copies of 42 C.F.R.

☐ Attached ☐ See Prior Application ☐ New Satellite Ref. Lic. #_____

J. **ALL RESIDENTIAL PROGRAMS** are to attach evidence meeting fire inspection requirements by fire safety authorities. The inspection must have been performed within the last 12 months.

☐ Attached

K. **RESIDENTIAL PROGRAMS** who provide sub-acute detoxification and/or ASP services MUST complete application (BHS/L&C-105) and submit all required attachments listed therein.

☐ Attached ☐ See Prior Application ☐ New Satellite Ref. Lic. # _____ ☐ N/A

L. **NEW APPLICANTS (including new satellites)** must send a NOTICE OF INTENT to churches, schools and incorporated non-profit civic organizations in the program's proposed service delivery area when they intend to provide substance abuse treatment, rehabilitation and/or prevention services. Send a copy of the published notice or evidence that the notice was distributed. SEE EXAMPLE BELOW.

☐ N/A

EXAMPLE

NOTICE OF INTENT

(Name and address of applicant program) has applied for a substance abuse license through the Michigan Department of Community Health, Substance Abuse Licensing Section. The license will allow us to provide (type of service to be licensed) substance abuse services. Comments should be directed to (Name and address of coordinating agency).

ASSURANCES

As program director, I am responsible to the governing authority of this program or its authorized agent for overall operation of the program. I have reviewed Article 6 of Public Act 368 of 1978, as amended, and the administrative rules applicable to the service(s) provided by this program, I believe my program is in compliance with the rules and the Act and is ready for on-site inspection.

I understand that I may request a waiver of a license rule and that it is my responsibility to complete the appropriate section of the application for a renewal of waiver or to submit a waiver request form for a new waiver request.

I authorize the Chief of the Substance Abuse Licensing Section or his or her representative to obtain from any source, information as to my ability to comply with Article 6 of Act 368 of 1978 as amended, and the Administrative Rules (R 325.14101 - R 325.14928).

I further certify that the information furnished in this application is true and accurate. Any information found to be false may result in my application being denied and my program licensure being revoked. Supportive documentation will be furnished upon request of the Substance Abuse Licensing Section. I have completely filled out this application and understand that if the application is found to be incomplete, the licensing process will be suspended until I have furnished missing or incomplete information.

By signing this application for licensure, I acknowledge that should any information contained in this application change, notice of the change will be immediately provided to the Substance Abuse Licensing Section. Failure to do so may invalidate the license. I understand notice of change of ownership, governing authority or location must be submitted to the Substance Abuse Licensing Section thirty (30) days before the change takes effect. A copy of this application and attachments and subsequent changes to it will be maintained at my program.

A copy of this application and attachments have been sent to the following coordinating agency:

_____ on _____
Date

The original application is being submitted to the Substance Abuse Licensing Section.

Signed: _____ _____
Program Director Date

As a member or designee of the applicant program's governing authority, I certify that the governing authority has the authority and responsibility for overall operation of the program and will ensure that the program complies with the applicable licensing standards.

Signed: _____ Date _____

Printed: _____ Title _____

REGIONAL SUBSTANCE ABUSE COORDINATING AGENCIES

01. PATHWAYS
Substance Abuse Coordinating Agency
369 U.S. 41 East
Negaunee, MI 49866-1325
(906) 228-2572
Serving: Alger, Chippewa, Delta, Luce, Mackinac, Marquette, Menominee, Schoolcraft Counties

08. NORTHERN MICHIGAN SUBSTANCE ABUSE SERVICES, INC.
1165 Elkview Drive, Ste. 1
P. O. Box 1278
Gaylord, MI 49734
(989) 732-1791
Serving: Alcona, Alpena, Antrim, Benzie, Charlevoix, Cheboygan, Clare, Crawford, Emmet, Gladwin, Grand Traverse, Isabella, Iosco, Kalkaska, Lake, Leelanau, Manistee, Mason, Mecosta, Midland, Missaukee, Montmorency, Oceana, Osceola, Ogemaw, Oscoda, Otsego, Presque Isle, Roscommon, Wexford Counties

09. GENESEE COUNTY HEALTH DEPARTMENT
Floyd J. McCree Courts & Human Services Building
630 South Saginaw Street
Flint, MI 48502-1540
(810) 257-3201
Serving: Genesee County

10. ST. CLAIR COUNTY HEALTH DEPARTMENT
Thumb Region Substance Abuse Services
Coordinating Agency
3415 – 28th St.
Port Huron, MI 48060
(810) 987-8922

Serving: Lapeer, Sanilac, St. Clair Counties

11. MID-SOUTH SUBSTANCE ABUSE COMMISSION
2875 Northwind Drive, Suite 215
East Lansing, MI 48823
(517) 337-4406
Serving: Calhoun, Clinton, Eaton, Gratiot, Hillsdale, Ingham, Ionia, Jackson, Lenawee, Newaygo Counties

14. KALAMAZOO CO. COMMUNITY MENTAL HEALTH SERVICES,
Substance Abuse Services, Regional Coordinating Agency
Nazareth Complex
3299 Gull Road, P.O. Box 63
Nazareth, MI 49074-0063
(269) 553-8150
Serving: Barry, Branch, Kalamazoo, St. Joseph, Van Buren Counties

15. SUBSTANCE ABUSE SERVICES NETWORK OF WEST MICHIGAN
728 Fuller Ave., NE
Grand Rapids, MI 49503
(616) 336-3765
Serving: Kent County

20. MACOMB CO. COMMUNITY MENTAL HEALTH
Office of Substance Abuse Services
Macomb County Building, 6th Floor
10 North Main Street
Mt. Clemens, MI 48043
(586) 469-5278 & 469-5920
Serving: Macomb County

27. OAKLAND COUNTY HEALTH DIVISION
Office of Substance Abuse
250 Elizabeth Lake Road, Suite 1550
Pontiac, MI 48341-1050
(248) 858-0001
Serving: Oakland County

28. LAKESHORE COORDINATING COUNCIL
324 Washington Street
P. O. Box 268
Grand Haven, MI 49417-0268
(616) 846-6720
Serving: Allegan, Berrien, Cass, Muskegon, Ottawa Counties

29. SAGINAW COUNTY HEALTH DEPARTMENT
1600 North Michigan Avenue, Ste. 501
Saginaw, MI 48602-5395
(989) 758-3745
Serving: Saginaw County

33. WASHTENAW COMMUNITY HEALTH ORG.
Livingston-Washtenaw Substance Abuse
Coordinating Agency
P. O. Box 915
555 Towner Street
Ypsilanti, MI 48197
(734) 544-3000
Serving: Livingston, Washtenaw Counties

34. DETROIT DEPARTMENT OF HEALTH
Bureau of Substance Abuse
Herman Kiefer Health Complex
Main Bldg., Rm. 317, B Wing
1151 Taylor
Detroit, MI 48202
(313) 876-4566
Serving: City of Detroit

35. WESTERN U.P. SUBSTANCE ABUSE SERVICES
COORDINATING AGENCY
903 W. Memorial Drive
Houghton, MI 49931
(906) 482-7710
Serving: Baraga, Dickinson, Gogebic, Houghton, Iron, Keweenaw, Ontonagon Counties

40. SOUTHEAST MICHIGAN COMMUNITY ALLIANCE
25363 Eureka Rd.
Taylor, MI 48180
(734) 229-3500
Serving: Monroe & Wayne Counties

41. BAY ARENAC BEHAVIORAL HEALTH
Riverhaven Coordinating Agency
306 Fifth St., Ste. 300A
Bay City, MI 48708
(989) 895-2251 or 2371
Serving: Arenac, Bay, Huron, Montcalm, Shiawassee, Tuscola Counties